LETTERS TO THE EDITOR

Methicillin resistant *Staphylococcus aureus* (MRSA) balanoposthitis in an insulin dependent diabetic male

EDITOR,—Balanoposthitis is a common condition affecting 11% of the male attendees at GUM clinics.[1] It is an inflammation of the glans penis and the prepuce, and its causes include bacterial and yeast infections, parasitic infestations, trauma, and irritants.[2] However, to our knowledge, no case has been reported to be caused by MRSA.

A 49 year old insulin dependent diabetic man who was an inpatient for repair of an upper jaw fracture developed a penile itch with swollen foreskin, which was difficult to retract, together with longitudinal fissures on the prepuce and subpreputial discharge. In his recent past he had had two incidents of unprotected sexual intercourse with two known females. He was clinically diagnosed as having candida balanitis and was commenced on clotrimazole cream, which did not produce a clinical response over the course of a week. The swabs taken before the commencement of clotrimazole cream failed to grow candida; however, MRSA resistant to erythromycin, penicillin, and flucloxacillin but sensitive to mupirocin was isolated.

Screening tests for chlamydia, gonorrhoea, and trichomonas were negative.

A 10 day course of mupirocin 2% ointment completely resolved his symptoms.

Subpreputial swab after treatment was negative.

MRSA has been a well recognised cause of hospital acquired infections worldwide since it was first detected in Europe in the 1960s.[3] The organism can survive for long periods in both the hospital and the home environment and can colonise the skin, nose, or throat of patients and healthcare staff.[4] Several reports have suggested that diabetic patients are more susceptible to *Staphylococcus aureus* bacteraemia[5] MRSA has been isolated from different sites in diabetic patients but not the genitalia.[6] MRSA rarely invades intact skin; however, it can give rise to severe infections—for example, wound infection, bacteraemia, endocarditis, and osteomyelitis.[7]

This case illustrates the fact that MRSA is an organism to consider in patients who develop balanoposthitis while in hospital or shortly after discharge especially those whose immune system is incompetent.

There may be implications of spread of MRSA in the community for sexual contacts of patients carrying MRSA in the genital area.

Contributors: Both authors managed the patient and wrote the manuscript.

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Chlamydia trachomatis reinfection rate: a forgotten aspect of female genital chlamydia management

EDITOR,—Hillis *et al*[1] reported that repeated episodes of infection of female genital tract with *Chlamydia trachomatis* increase the risk of hospital admission for pelvic inflammatory disease and ectopic pregnancy. The first diagnosed attack of genital infection with chlamydia presents the clinician with a unique opportunity to implement measures to minimise the risk of reinfection—that is, health promotion and contact tracing.

During April–June 1998 we reviewed the case notes of female patients who were diagnosed with genital chlamydia at Leicester Royal Infirmary and Derbyshire Royal Infirmary GUM clinics in the year 1996 for evidence of repeat episode of genital chlamydia. We also noted the following data: age at presentation with the first episode of infection, time for presentation with reinfection, test of cure if performed, co-infection with gonorrhoea, review by health adviser, contact(s) traced and treated in the first 3 months after diagnosis. For the purpose of the study we defined reinfection as a patient testing positive for genital chlamydia 30 days or more after the completion of treatment. We also looked at the genital chlamydia treatment protocols in both clinics.

A total of 540 female patients were diagnosed with chlamydia (311 at Leicester and 229 at Derby). The patients' mean age at first episode was 22.6 years for Leicester and 23.4 years for Derby. The health advisers had made contact with 94.5% (294) in Leicester and 97.8% (224) in Derby; 85.2% (265) of the patients diagnosed at Leicester returned at 30 days or more and were retested for chlamydia compared with 87.3% (200) at Derby; 9% (24) episodes of repeat infection were identified in Leicester group compared to 17% (34) episodes in the Derby cohort. The mean period for presentation with reinfection was 9.4 months (range 3–25) at Leicester and 9.8 months (range 2–24) at Derby. At Leicester the contacts of 66.5% (207) patients were traced and treated compared to 64.6% (148) at Derby. A test of cure was performed on 282 patient in Leicester (where it was routine practice); 2.5% (seven) were found to be positive for chlamydial infection, while the test of cure was performed on 22 patients in Derby (where it was performed selectively) revealed no positive cases.

Of the reinfected patients 58.3% (14) at Leicester were reinfected because of failure to trace and treat their partner(s) compared to 35.3% (12) at the Derby clinic.

Both clinics manage genital chlamydia with what was considered standard treatment and perform contact tracing wherever possible. Two reinfected patients from each clinic were also co-infected with gonorrhoea.

Other risk factors for reinfection—for example, ethnic origin, number of sexual partners,[2] were not analysed as these data was not discernible from the notes.

This retrospective study highlights the fact that a substantial number of patients get reinfected with chlamydia despite health education and counselling by health advisers. Though the figures (66.5% and 64.6%) for partner notification and treatment were close to that proposed by the Central Audit Group (70%)[3] the proportion of those reinfected is still too high. Does the message that repeat episodes of genital chlamydia are more damaging get through to our patients or do we need a new health education strategy?

Currently, as the success of management of genital chlamydia is evaluated by the level of contact tracing, the number of patients referred to health advisers, and number of contacts per index patient seen and treated,[4–6] we believe it is time to evaluate outcome measures in terms of reinfection rates. Large prospective studies need to be done to elucidate this aspect of chlamydial infection management.

Contributions: PS had the original idea; EH collected and analysed the data EH and JD wrote the manuscript.

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The Society of Apothecaries Diploma examination in Genitourinary Medicine: death of the viva voce?

EDITOR,—The London Apothecaries Diploma in Genitourinary Medicine is likely to become even more important in the near future as all specialist registrars and probably